Management Sciences for Health/Leadership, Management and Sustainability (LMS) Program

Democratic Republic of Congo (DRC) Primary Health Care Project in West/Central Congo

Assessment Report

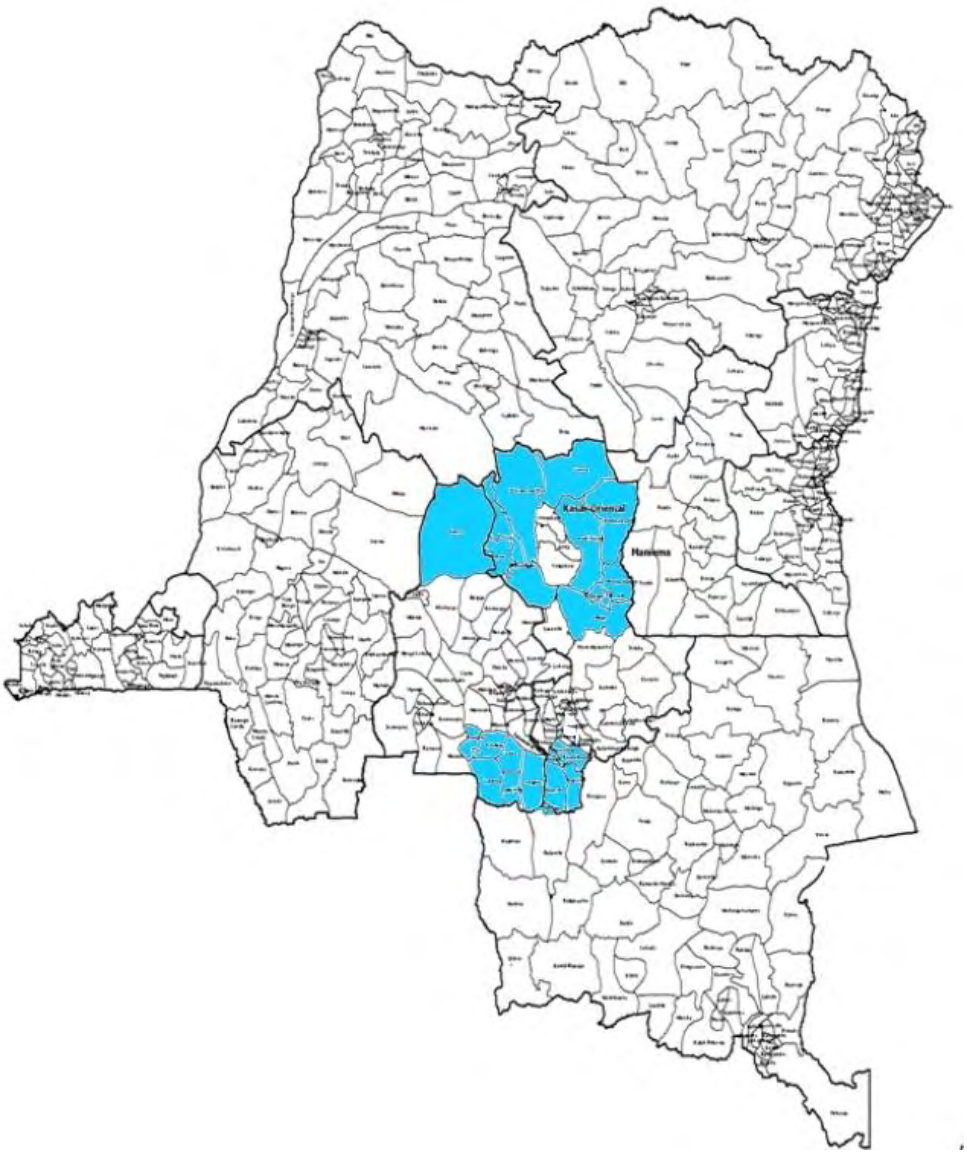
FINAL

November 2008

I. Purpose of Assessment: USAID/Democratic Republic of Congo has requested that The Management Sciences for Health (MSH) Leadership, Management and Sustainability Program (MSH/LMS), GPO-A-00-05-00024-00, provide quality primary health services and strengthen primary health care service delivery systems in 23 health zones in the Kasai Oriental and Occidental provinces, and at both the provincial and health zone levels. The target population is about 3 million people. The first LMS visit to DRC took place in September-October 2008 to conduct an assessment of the primary health care services implemented in the 23 health zones in the Kasai provinces and possibly select additional health zones. During the assessment, the team met with Ministry staff, donors, and health care providers. The team conducted site visits to selected health zones (Luiza, Masuika), visiting hospitals and health centers and observing the delivery of primary care services. The LMS health zones with corresponding population and number of health areas (*aires de santé*) are listed below.

HEALTH ZONES	HEALTH AREAS	POPULATION
KASAI ORIENTAL		
Dikungu	17	114,264
Tshumbe	14	78,600
Katako Kombe	17	108,835
Djalo Ndjeka	14	64,882
Minga	18	129,306
Wembo Nyama	15	68,294
Kole	11	71,040
Bena Dibele	10	69,500
Lomela	18	91,180
Tshudi Loto	11	62,875
Kandakanda	18	186,573
Kalenda	24	167,952
Luputa	30	231,861
Makota	16	187,769
Mwene Ditu	18	334,407
Wikong	16	94,962
KASAI OCCIDENTAL		
Dekese	18	116,435
Kalomba	15	120,568
Luambo	23	217,976
Luiza	18	137,456
Masuika	19	163,794
Tshibala	20	194,969
Yangala	25	122,467

As a result of the assessment LMS will develop and implement a strategy and a workplan, which will include a description of the problem, strategy, indicators, targets and timeline for implementation, which USAID/DRC will review and approve. It is expected that while LMS is ensuring USAID-supported health zones function optimally and provide quality primary health care services, the project will also work closely with government at the provincial level to develop and implement a strategy to strengthen the capacity at that level. At the end of this 5-year project, MSH/LMS envisions a Ministry of Health that is capably supporting the full implementation of quality comprehensive primary health care services in collaboration with partners at the health zone level. MSH/LMS aims to focus on support and capacity building rather than creating a parallel system.



II. Goals and Objectives:

Project Goal: To contribute to the reduction of newborn, infant, child and maternal morbidity and mortality in 23 health zones of the Kasai Occidental and Kasai Oriental provinces (building upon the current USAID work there).

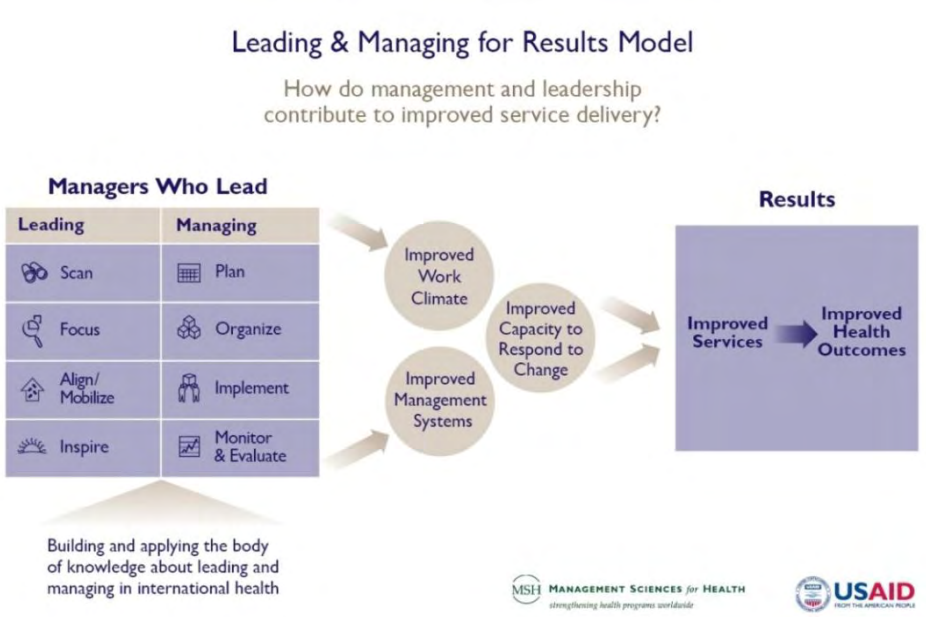
Project Objectives:

1. Increase the quantity and quality of health services offered to about 3 million people in the Kasai Oriental and Kasai Occidental provinces.

2. Increase demand and service utilization in the target health zones;

3. Strengthen local capacity (GDRC and NGO partners) in the management and delivery of health services.

These objectives will be accomplished through **strengthened public health and clinical skills, improved overall health service delivery through the implementation of Fully Functional Service Delivery Points, and reinforced leadership and management** from the provincial and especially to the health zone level, maintaining a focus on public health results and fostering leadership and management skills and practices among managers at these levels. To improve the health outcomes, MSH/LMS will foster ownership, commitment, and energy to lead towards the expected results: sustainable improvements in health care. This will be accomplished through a model that unites a Fully Functional Service Delivery Point (FFSDP) methodology with a leading and managing (M&L) for results approach, and eventually, if appropriate, a performance-based funding (PBF) component. The combination of these three approaches would be the most powerful to rapidly scale up services (PBF) while assuring quality (FFSDP) and sustainability (M&L). The results model below illustrates how leading and managing practices will help build the organizational capabilities that result in improved health services and, ultimately, improved health practices:



III. Background:

In 2005, the DRC Ministry of Health, in partnership with donors, developed a new strategy for health care delivery, *Stratégie de Renforcement du Système de Santé* (SRSS) which involves using health zones as the entry point for all health interventions. The health zone approach had been implemented in the 1980s before the civil strife and proved an effective method for health care delivery. Currently, all health care services are delivered at the health zone level and the government has developed guidelines for a minimum package of services including basic curative care, immunization, reproductive health and child spacing, maternal care, malaria, TB, HIV/AIDS and blood safety, and drug supply. Donors have selected various provinces and/or health zones within provinces to support.

Since 2002, through CRS, USAID has been supporting services in 23 health zones within Kasai Oriental and Kasai Occidental Provinces plus two additional health zones in the Bas-Congo Province. In those health zones, USAID provides support for a limited minimum package of basic health services (basic curative care, immunization, maternal care, malaria, blood safety and HIV-AIDS universal precautions), small renovation projects, drug supply, improving management of health facilities, and strengthening the quality of health services delivered, including provider performance and supervision.

The implementing partners for CRS have been the DRC Catholic network of *Bureaux Diocésains des Oeuvres Médicales (BDOMs).* There are 47 Catholic Dioceses in DRC: CRS is working in 4 of them: Kisantu, Kole, Luiza, and Tshumbe. The health zones are in very isolated, hard to reach rural health zones in Kasai Oriental and Kasai Occidental (the two in Bas Congo are no longer part of this project). The current activity, focusing on preventive and curative primary health care services in the Kasai Provinces, began originally in 16 health zones in the Catholic Dioceses of Tshumbe, Luiza, and Kole. Luiza and Kole Dioceses include parts of both Kasai Oriental and Kasai Occidental. In 2003, the MOH revised the geographic subdivision of health zones countrywide, resulting in an increase from 306 to 515 health zones. As a consequence, the original USAID-supported CRS zones became 23, with 7 new health zones, some of them without a General Reference Hospital (GRH). CRS also received a centrally-funded Child Survival Grant (CSG) to complement USAID assistance in the 7 new health zones mentioned above. CRS will continue to carry out these grant activities in the Kasais even though its main involvement in the health zones will be transitioned to MSH.

Due to extremely difficult transportation logistics as well as mismanagement, stock outs of medicines and supplies are common. As a result, there is a gap in achieving results among BDOMs *(Bureaux Diocésains des Oeuvres Médicales).* USAID has noted that the curative services utilization rate varied between 13% (BDOM Luiza) and 42% (BDOM Kisantu) for 2007. The overall DPT3 (third dose of Diphtheria, Pertussis, Tetanus vaccine) immunization rate was above 85%, except for BDOM Kole, where it was 76%.

In late February through March 2008, a team comprised of staff from USAID/DRC, USAID/Washington, USAID/East Africa Regional Office, CDC, and the DRC MOH conducted an assessment of the USAID health program in DRC. This team found that although USAID/DRC has had an impact on the provision of health services, the need is so great that critical weaknesses continue to pose major challenges within the overall system. Some of the key challenges include:

- **A fragmented and ad hoc health care delivery system**: Each donor supports certain health zones and there are a variety of faith-based organizations (FBOs), non-governmental organizations (NGOs), and donors delivering services within those zones. Coordination among donors and the Ministry is critical to facilitate harmonization and standardization of services.
- **Need to strengthen provincial level management of health services**: The Constitution of the DRC states that government will be decentralized. Consequently provincial systems will need to be strengthened to manage health care services delivered at the zonal level. Provincial level management of health services is a totally new concept and practice. Provincial functioning including management, coordination and communication must be strengthened between provincial and national levels as well as downward with the local/zonal level.
- **Need to address issues of low staff morale as well as underpaid/ overworked/ underutilized health staff**: Health staff skills are weak, and in general, a strategy to build the leadership and management capacity as well as improve the morale of the health staff is critical to ensure quality services are provided. The government is particularly challenged, as it does not have the resources to fund the health care system at the levels needed. In addition to developing provider capacity and morale, it will be important to explore, where possible, potential cost recovery strategies and promote program sustainability.

IV. Proposed Project:

In keeping with its commitment to strengthening the GDRC primary health care system to ensure that quality comprehensive primary health care services are accessible and delivered, USAID has requested that MSH/LMS address the above challenges to maximize project impact. MSH/LMS is to ensure the following services are included:

- **Maternal and Child Health (MCH):** All MCH sub-elements should be targeted as the current program in the Kasai did not implement some of them due to limited funds. Specifically, treatment of obstetric complications and disabilities, newborn care and treatment, and integrated management of childhood illnesses (IMCI) were not covered. Although health facilities stated IMCI was implemented, it was clear from the USAID/CDC/MOH assessment team report that many facilities were unable to provide all the services needed. This will necessitate the development and strengthening of community based capacity to manage IMCI services and collaboration between the community and health care facilities. Immunization, micronutrients, birth preparedness and maternity services need to be consolidated.

- **Obstetrical fistula referral services:** LMS will deal with incidence of vaginal fistulas caused by the lack of access to maternity care and early pregnancy due to early marriage (common practice in the Kasais) or gender based violence. LMS will provide education and training to health care providers in the causes and prevention of obstetrical fistulas, as well as developing a system of referral for those women who suffer this morbidity. Surgical repair will be made available in selected hospitals by subsidizing the care and assisting physicians in strategically selected surgical centers to be better trained in surgical repair of genitor-urinary fistulae. Fistula prevention also is essential, and prevention will include community sensitization and earlier referral to facilities where cesarean sections are offered. The project will explore the feasibility of "waiting homes" near such facilities for high-risk clients.

- **Integration of infectious disease services for TB, Malaria and HIV**: Coverage of Direct Observed Short-course Treatment Strategy (DOTS) specific to case detection and treatment of TB needs to be strengthened and expanded. Malaria prevention and treatment requires emphasis on ensuring an integrated approach with antenatal and child health care, appropriate treatment of pregnant women, access to bed nets, and adherence to national protocols. HIV services, such as prevention education, VCT, care and support need to be actively integrated into the primary care services and TB treatment programs. Health zones also lack supplies and trained personnel for accurate diagnosis and treatment.

- **Rapid response capability**: Provincial and health zone systems must have a rapid response capacity to identify/diagnose and address outbreaks of Ebola, cholera and other infectious diseases.

- **Integration of RH/FP and HIV services**: Activities should be coordinated with the drug logistics and supply system to access necessary commodities. Additionally, ongoing community education and promotion of family planning services including fistula to increase women's understanding of and access to services available will be reinforced. Training must be provided to increase providers' awareness and knowledge of these issues and reduce bias and/or discrimination.

- **Water and sanitation**: Access to clean water and support of hygiene promotion in households and villages through the promotion of the *"village assaini"* concept will be included in project activities.

MSH/LMS will strengthen the primary health care delivery system in Kasai Oriental and Occidental at all levels: national, provincial, and zonal. LMS has a record of experience and success developing and strengthening primary health care systems focused on service delivery. Some countries presenting challenges similar to DRC where LMS is currently working include Afghanistan and Haiti. By strengthening management systems and improving leadership at all levels, LMS improves the performance of health care organizations, develops human resources, and builds the capacity to anticipate and respond effectively to changing external environments. LMS works at all levels within health care organizations and programs to provide key management and leadership skills to effectively address change and improve health outcomes in

the areas of family planning, reproductive health, HIV/AIDS, infectious disease, and maternal and child health.

Additionally, MSH/LMS has demonstrated that a performance-based funding (PBF) component can be successful in fragile state environments similar to the DRC. In Haiti, MSH uses PBF with a network of 35 local NGOs that serve one-third of the population. These NGOs have achieved and maintained dramatic improvements in immunization and attended births. Through performance-based grants to 29 NGOs, the REACH Project in Afghanistan brought basic health services to 7 million people in 13 provinces. Another successful example includes PBF in Rwanda. Although it has not yet been decided to implement PBF in DRC, in consultation with USAID and other project stakeholders, LMS will investigate the possibility of this option during the second year of implementation. An assessment was originally envisioned for the first year of the project, but at the time of the assessment and in discussion with USAID, we made a decision to delay this component to the second year of the project.

V. Statement of work

USAID/DRC requested MSH/LMS assistance to accomplish the following**:**

1- Assess current primary health care system and develop a strategy that can be implemented for short and long-term solutions. Short-term solutions will address strengthening primary care service delivery at the zonal level. The long-term solutions will continue to strengthen zonal capacity while also strengthening capacity at the provincial level to manage health services and function effectively both at the health zone and provincial levels.
2- Strengthen leadership and management skills at the health zone and provincial levels.
3- Assist in developing a strategy/model to ensure a more coordinated primary health care system implementing standardized services, initially within the USAID funded health zones and possibly scaling up across the DRC.
4- Develop the capacity and integrate a community case management component which will interface with services at the health facilities to ensure follow up and coverage at the community level.
5- Implement primary care services in the 23 current USAID-assisted health zones in Kasai Oriental and Kasai Occidental with the option of choosing additional two health zones for a total of 25.
6- Work with health facilities focusing on: strengthening the technical capacity of providers; quality of care provided; supervision provided; provider morale; and overall facility functioning to ensure client satisfaction.
7- Based on assessment and discussions with USAID staff, develop a performance based funding strategy to enhance service provision and provide cost recovery, allowing for opportunities to increase benefits to providers.

VI. Selected anticipated results

Below are the **results** suggested by USAID/DRC for this project. Additional management and leadership indicators are proposed in the next section (with the precise results expected to be determined through the development of team actions plans), and other results associated with implementing the Fully Functional Service Delivery System, described below, will be refined as the approach is implemented.

Indicator	Result
DPT3-Hep B coverage	90%
Drop out DPT1-HepB/DPT3-HepB	10%
Children under one year of age receiving measles vaccination	90%
Diseases related to vaccinations detected and reported within 14 days	80%
Children aged 6-59 months who have received vitamin A during each campaign	95%
Children 12-59 months who have received mebendazole during each campaign	95%
Pregnant and lactating women visiting health centers who have received iron supplements	90%
Children with diarrhea who receive (low-osmolarity) ORS (Oral Rehydration Salts)	70%
Children with diarrhea who have received zinc	70%
Lactating women who practice exclusive breastfeeding before 6 months	60%
Lactating women who use appropriate weaning practices from 6 months	60%
Children under the age of five with ARI cared for correctly by health structures following national policy guidelines	90%
Children under the age of five with diarrhea illnesses cared for correctly by health structures following national policy guidelines	90%
Pregnant women in targeted health zones who receive IPT	90%
Severe malaria cases treated appropriately within 24 hrs	90%
Pregnant women and children under the age of five protected by LLINs in targeted health zones	60%
Detection rate for expected new cases consistent with WHO standards is maintained (SANRU experience was 51 to 71%)	70%
Cure rate for the collective TB treatment centers covered by the project consistent with WHO standards is maintained (SANRU experience was 72 to 84%)	85%

Households in targeted health zones with access to potable water	45%
Households in targeted health zones who adopt three key hygiene practices (use of potable water, use of latrines, and hand-washing)	50%

VII. Proposed indicators (a complete PMP will be submitted with the proposed workplan)

Below are the **indicators** proposed by USAID for the LMS/DRC Project, organized by health outcome. These indicators will be refined according to the approach described below for Fully Functional Health Service Delivery Points (FFSDP) and will include the health indicators necessary to track public health progress. Additional management and leadership-oriented indicators are suggested as well.

MCH	Malaria	Tuberculosis	FP/RH	Water/Sanitation	FFSDP & M&L (to be refined with action plans)
# of postpartum /newborn visits within 3 days of birth in USG-assisted programs	**# of ITNs distributed that were purchased and subsidized with USG support**	**% of the Estimated Number of New Smear positive TB Cases that were detected under DOTS**	**Couple-years of protection (CYP)**	**% of households in targeted health zones that have access to potable water**	**% of health facilities with functional delivery rooms**
# of antenatal care (ANC) visits by skilled providers from USG-assisted facilities	**# of medical and paramedical practitioners trained in evidence-based clinical guidelines**	**% of all registered TB patients who are tested for HIV**	**# of counseling visits for FP/RH as a results of USG assistance**	**% of households in targeted health zones adopt three key hygiene practices (use of potable water, use of latrines, and hand-washing)**	**# of organizations applying management and leadership practices to address challenges in improving organizational performance and health service delivery**
# of people trained in maternal/newborn health through USG-supported programs (women – men)	**# of people trained in malaria treatment or prevention**	**% of TB patients successfully treated**	**# of people that have seen or heard a specific FP/RH message**		**# of organizations addressing management challenges to improve organizational performance**
# of deliveries with a skilled birth attendant (SBA) in USG-assisted programs			**# of policies or guidelines developed or changed to improve access to and use of FP/RH services**		**% of health facilities with adequate waste disposal systems**
# of people trained in child health and nutrition through USG-supported health area programs (women – men)			**# of new approaches (e.g. tools, technologies, operational procedures, information systems, etc.) successfully introduced**		**% of health facilities doing physical stock of drugs/supplies inventory**
# of women receiving Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs			**# of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP at any time**		**# of health facilities ordering based on stock surveillance**

			during the reporting period		
# of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs			# of service delivery points providing FP counseling or services		% of health facilities with adequate equipment
# of newborns receiving essential newborn care through USG-supported programs			# of people trained in FP/RH(men-women)		% of health facilities with basic drug/supply management system
# of children reached by USG-supported nutrition programs					% of health facilities with adequate staffing
# of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs					% of health zones with required number of midwives/community midwives
# of children less than 12 months of age who received DPT3-HepB from USG-supported programs					% of health facilities performing training needs assessments
# of children under 5 years of age who received vitamin A from USG-supported programs					% of health facilities with required HMIS reports available
# of cases of child diarrhea treated in USAID-assisted programs					% of health facilities with map of catchment areas with responsible health provider identified by sections
					% of health facilities with register of all referrals to a higher level
					% of health facilities with clinical guidelines for major areas of health services available at health facility

VIII. Findings and recommendations from the September-October in-country assessment visit

From September 28-October 11, 2008, an MSH/LMS team visited DRC to conduct an initial assessment and to begin formulating ideas for the LMS project in country. Stakeholder contact information and documents consulted for the assessment are included at the end of this report. Due to limited time and difficult logistics, the team was only able to visit Kinshasa to meet with key partners and then go to a small number of future LMS health zones. The team flew to Tshikaji, met with provincial-level officials in Kananga, and then went by road to Luiza Health Zone. From there, the team was also able to visit Masuika Health Zone. Although the number of health zones visited was limited, these locations provided a good snapshot of the situation in many of the LMS health zones.

Based on the discussions both in Kinshasa and in the health zones, the team found the following issues to be of key importance to the stakeholders in the LMS project:

1. **Drug supply management systems**: All partners with whom the team met described numerous problems with the drug supply and management in the country. One problem is that in the areas where drugs are available, the quality is not assured, and the prices are high. Often the prices change from one health structure to the next. The revolving fund has with little exception been mismanaged. Stock outs of essential medicines are common, and we observed that the stocks of medicines in most of the pharmacies that we saw were inadequate. The BDOM in Luiza noted that it was impossible to keep a revolving drug fund in place because the health zones had not well understood how the fund was supposed to work (health zones mismanaged the funds, in some cases, with Masuika telling us directly that they had used the proceeds from the sale of the drugs to give themselves bonuses). In addition, transport of drug supplies is challenging. CRS did not supply contraceptives, but a two-year CARE project was to have left in place enough contraceptives to last through December. Some evidence of that project was found at the health zone pharmacy in Luiza, but the supply was less than adequate and did not include all methods of family planning.

   Recommendation: MSH will follow USAID's lead on this issue. A new procurement is expected to provide services to all of the USAID-funded projects. It was not evident at the time of our visit whether this would include procurement and distribution to just the province level or whether this would extend down to the health zones. We will also rely on USAID's advice concerning any changes in DRC policies that seem to be in effect (advertising for FP methods, permission from men to use FP, etc.). In terms of the management of the systems in place in the health zones, however, MSH/LMS will actively ensure that appropriate management systems are put into place and used. LMS will also look creatively at transportation of drug supplies to the health zones, and will explore potential ways to expedite initial drug supply (such as coordinating through the existing AXxes Project. If the new activity does not provide for procurement and distribution to the health zone level, MHS/LMS will consider additional ways to get drugs to their destination, including potentially purchasing delivery trucks.

2. **Equipment/materials**: There were many examples of how ineffective the current situation is for almost all needed equipment and materials in the health zones. For example, CRS provided the BDOMs with funding to purchase fuel and distribute it to the health zones. While this has worked at times, at others the health zones report having to go and get the fuel themselves, sometimes renting a truck at $3000 per trip to go get fuel in Kananga and bring it back. The practice of having the BDOMs purchase and distribute fuel has not functioned as planned. The BDOM has not carried out all of its designated responsibilities in the cluster of zones in and around Luiza. According to everyone interviewed in Luiza and Masuika, every single vehicle supported by the CRS project broke down at exactly the same time. It seems more likely that the vehicles were mismanaged, since further questioning revealed that there had been no system of utilization or maintenance for the vehicles. Health zone personnel noted that support for operational materials (such as office supplies, etc.) had been inadequate.

   Recommendation: LMS/DRC should consider a different model of fuel distribution, including the possibility of buying and storing fuel in cisterns and distributing it to the health zones from the local MSH offices. LMS will review the equipment, material, and supply needs of its health zones as part of an overall participatory rapid assessment starting in January 2009 (participatory in that the district health offices and other appropriate stakeholders will be included as partners in the assessment). It is anticipated that not all needs of each health zone will be met in the first year of the project, but the assessment will determine the priorities and identify what is essential for immediate support. All project resources will be managed through a system that accounts for who

will use them, how they will be used, how they will be maintained, etc. We will build local capacity to track the use of resources, particularly vehicles, according to standards for other MSH USAID-funded projects. MSH/LMS also will consider including in its support a well-managed maintenance system for project vehicles that will focus on building local capacity to adequately maintain these resources.

3. **Leadership and management skills at all levels**: It is clear that a change in behavior and mindset, as well as in management and leadership practices and competencies, needs to occur to enable effective delivery of health services in the LMS health zones. From the provincial to the zonal levels, teams need to be reinforced to be responsive as well as to take initiative. From the General Secretary of the Ministry of Health down to the health zone level, stakeholders noted that there is a real problem of motivation of health personnel at all levels. There is also a clear notion that "motivation" refers to much more beyond monetary reward (although this is certainly an issue as well). Those involved in health service delivery need to understand their roles and responsibilities in the health system, as well as to have a clear understanding of the greater purpose of their efforts—serving the population with high-quality health care services. Currently, and with few exceptions, stakeholders' responses to questions about strengths and vulnerabilities of the current health system are focused much more on the resources going into the system rather than the clients who are served by the system and the impact of the system on their health.

   Recommendation: The combination of the Fully Functional Service Delivery Point methodology with reinforcement from tools such as the proposed Leadership Development Program (LDP) will reinforce the necessary competencies and practices and inspire appropriate behavioral changes. The five principles of leadership that serve as the basis for the LDP program, for example, will lead to substantial changes in the health zones: (1) **focus on health outcomes**: good management and leadership result in measurable improvements in health services and outcomes; (2) **practice leadership at all levels**: god leadership and management can and must be practiced at every level touched by the project; (3) **people can learn to lead**: leadership practices will improve through a process of facing challenges and receiving feedback and support, and through the use of this process, managers will also develop the leadership abilities of their staff; (4) **leadership is learned over time**: becoming a manager who leads is a process that takes place over time and is best learned when the organization is supportive; and (5) **sustain progress through management systems**: gains made in health outcomes can only be sustained by integrating leadership and management practices into routine systems and processes. MSH/LMS will focus to a great extent on the health zone level, but it will also include the provincial health system in LDPs and other support for health system management. This is why we propose (as mentioned again, below, in the proposed structure for the project), that in provinces where we base our offices in a health zone close to a "cluster" of health zones, we consider the placement of a capacity building advisor who will also facilitate the Fully Functional Service Delivery Point model with the provincial offices as well (specifically in Kananga, but also in Mbuji Mayi if we base our office for that "cluster" in Mwene Ditu).

4. **Involving partners in assessments, workplanning, and interventions**: Potential project partners at all levels noted that the previous project had not kept them informed or involved in the project. At the central level, the Deputy Director of Reproductive Health noted that projects generally do not coordinate well with the Ministry. At the provincial level, stakeholders noted that they were not involved in planning or supervision of previous project activities and were unaware of what kinds of interventions were even taking place. At the health zone level, the same issues were repeatedly raised. Project stakeholders noted that they did not know the results of any of the reporting they provided to the project; that they were not involved in workplanning; that they did not know whether the renovation projects planned were completed because they did not

know what was supposed to be renovated in the first place; etc. It should be noted that we did not see great evidence of renovation aside from signs outside hospitals and health centers saying they had been renovated by the BDOM with the support of CRS and USAID; and even the BDOM supervisor who accompanied us to several of these facilities could not say what aspects were to have been renovated.

Recommendation: MSH/LMS will ensure that partners are involved in assessments at the health zone level where the major efforts of the project will be focused. At the central level, the Project Director/Technical Director will ensure that information is shared with the appropriate partners on project plans, indicators, and so forth. As requested by USAID, MSH/LMS will participate in technical working groups (such as the one on reproductive health) to ensure exchange of information and coordination with the participating partners and the Ministry of Health. Where good technical processes are in place (such as those of AXxes in Mbuji Mayi, for example), MSH/LMS will work with the implementing partners to ensure appropriate sharing of information and application of those processes in LMS-supported zones. In the cluster of health zones around Luiza, MSH/LMS will coordinate with HealthNet and other partners. We will request that USAID provide a letter of introduction to the project in January 2009 in order to introduce the activities and invite participation of the Ministry of Health and other stakeholders as well as to set stakeholder expectations at a reasonable level.

5. **Training**: Stakeholders noted a constant need for refresher training (particularly in pharmaceutical management) and the need to conduct additional training at the health zone level by those who have attended training. They also noted that they have had some training but lack the materials to carry out what they learned in their training. At the same time, these stakeholders express concern that training can take people away from their jobs for extended periods of time, even if it is needed to better perform their roles and responsibilities.

   Recommendation: The rapid assessment will help ascertain the technical training or refresher training that will be needed in the respective health zones. Training will be offered as much as possible in or close to the health zone level. It is not anticipated, for example, that LMS will bring health zone staff to Kinshasa for training; rather, training will be carried out in locations central to health zone "clusters" (such as in Luiza and Mwene Ditu) or in on-the-job situations through regular formative supervision and coaching. The *Médecins chef de zone* should always be implicated in training, to ensure their support and knowledge, but in a way that allows them to continue their work.

6. **Project management**: The CRS health zones have been managed by the BDOM. The results of this management are mixed, even by CRS' own account. By all accounts, financial and administrative management has been weak. Coordination with partners has been poor. The health zone of Masuika noted that that have been some improvements with the replacement of the BDOM team in Luiza about five months ago, but in general noted that there was no feedback on reports, no involvement in planning, etc. Partners also noted that CRS has been located only centrally, which has inhibited communication with the project management. CRS noted that management has indeed been centralized, and they recommended that be changed.

   Recommendation: The LMS/DRC project will have staff based in *Bureaux de coordination* near/in the health zones. This approach is described below in Section IX. The relationship with the BDOM needs to be redefined; they should not be excluded. We will explore how to appropriately involve them in the project's activities, perhaps at the level of community mobilization and communication. LMS will put into place systematic financial and financial controls that will be reinforced through capacity building of staff at the health zone levels. LMS will focus considerable effort on building management

systems for logistics, including management of transportation resources, as well as other aspects of effective project management.

7. **Monitoring and supervision**: Although a basic part of project management, monitoring and supervision deserve special attention. There is a clear need for strengthened monitoring and supervision systems for the health zones. This close supervision has been lacking in the Luiza cluster of health zones under the CRS project (which includes zones both in both Kasai provinces). More recently additional supervision has been carried out, but feedback systems related to these visits remain weak and it is unclear whether these supervisory visits are carried out in a supportive way. Stakeholders noted a lack of feedback as well as a lack of reinforcement of performance, as well as a lack of involvement of the Ministry of Health at any of the levels of supervision and monitoring.

   Recommendation: Each "cluster" of health zones should have two or three zonal supervisors who spend time in their assigned zones, reviewing progress and performance in the hospitals and surrounding health centers. Supervisory visits will be used in a supportive way, to reinforce on the job training and enhance performance. Ministry of health personnel will be included, with adequate remuneration, as part of the supervisory teams and their capacity to carry out supportive supervision with appropriate feedback will be reinforced.

8. **Health impact**: Interestingly, none of the stakeholders spoke about the health impact of the project without significant prompting from the MSH/LMS team. The *Inspecteur Medical* in Kananga did note that family planning has suffered because of the CRS support through the BDOMs, which do not accept offering family planning outside of natural family planning methods. This issue was discussed at all meetings during the team's trip to Luiza/Masuika. The family planning services previously offered by CARE seemed to be appreciated, and people had a positive impression of how well that program functioned. The BDOM noted that it was difficult to assess the health impact of the project because it was difficult to collect the data needed (the denominator being too difficult to determine to assess percentages of coverage for vaccination, for example). Nevertheless, we requested that the BDOM in Luiza provide us with performance indicators, and they were able to pull together a table that was current as of January 2008 (but that did not provide comparison to any desired results). In Masuika, health care providers were able to point to handwritten flipcharts on the walls with performance data by health indicators, but were unable to provide written reports. As noted elsewhere, all stakeholders noted that when they provided written reports to the BDOM in Luiza, they received no feedback. Family planning use is not reported by the BDOM, but the preliminary 2007 DHS indicated that in Kasai Occidental and Oriental Provinces the modern contraceptive prevalence varies between 1.9-2.1%. Other indicators seem to fall below the rated reported in the DHS: for example, prenatal care in the DHS was indicated to be 83.1 and 89.6% in Kasai Oriental and Occidental, respectively, and the BDOM/Luiza reported 75.9%; assisted births for Kasai Oriental and Occidental in the DHS were reported as 75.6 and 78.3%, respectively, while the data below indicate a rate of 60%. Vaccine coverage reported by the BDOM appears higher than rates reported in the DHS.

   The following table summarizes the results the BDOM provided in handwritten form; no computerized version appeared to exist.

Indicator		Frequency of collection	Summary for BDOM/Luiza		
			Number	Denominator	Result
Objective 1: Guarantee and Document Quality Primary Health Care Services					
% of supervision visits		Quarterly	2,850	3,300	86.4
% of health centers receiving 10 or more visits		Annual	226	264	85.6
Rate of completion of HMIS		Quarterly	3,000	3,300	90.9
% of health centers with an updated inventory		Annual	12	12	100
% of health zones with a census		Annual	1	12	8.3
Objective 2: Preventative and Curative Services Available and Used					
Vaccine coverage for children		KAP			
Vaccine coverage for children 0-11 months	BCG	Quarterly	65,608	79,927	82.1
	DTC3		64,138	74,839	85.7
	VPO3		65,591	74,839	87.6
	VAR		56,379	74,839	75.3
	VAA		58,424	74,839	78.1
Vitamin A coverage for 6-12 months		Annual	36,845	34,332	107.3*due to campaigns
Vitamin A coverage for 6-59 months		Biannual	393,626	383,124	102.7
Rate of loss for vaccination, DTC1-DTC3		Quarterly	4,853	66,008	7.4
Average number of days of stock out for vaccines	BCG	Quarterly	699	504	1.4
	DTC3		196	504	0.4
	VPO3		66	504	0.1
	VAR		398	504	0.8
	VAA		151	504	0.3
Coverage for Tetanus Toxoid		Quarterly	38,166	60,976	62.6
Percentage of households with treated bednets		Quarterly	102,352	290,817	35.2
Rate of use of prenatal services		Quarterly	60,689	79,927	75.9
Rate of use of postnatal visits		Quarterly	34,285	48,768	70.3
Rate of use of curative care		Quarterly	275,574	2,035,718	13.5
Rate of cure for TB		Quarterly	951	1,280	74.3
Percentage of health facilities reporting use of treatments	SP	Quarterly	71	275	25.8
	Bactrim		59	275	21.5
	Mabendazole		60	275	21.8
	ORS		60	275	21.8
Death rate	Measles	Quarterly	2	121	1.7
	Malaria		562	112,507	0.5
	ARI		262	34,937	0.7
	Diarrhea		92	22,977	0.4
	Malnutrition		109	8,406	1.3
	Maternal death		57	63,974	0.1
Rate of assisted births		Quarterly	47,953	79,927	60
Objective 3: Knowledge and attitudes about health behaviors					
Rate of villages targeted with community health workers		Quarterly	1,676	2,084	80.4
Objective 4: Essential prevention activities for integrated HIV/AIDS and PHC services					
Rate of blood tested for HIV		Quarterly	2,335	2,335	100
Percentage of health workers trained in universal precautions		Quarterly	0	1,558	0
Percentage of health workers trained in safe blood transfusion		Quarterly	0	1,558	0

Recommendation: Reorient all partners to the purpose of the project. Emphasize family planning and supplying the full range of family planning methods. Use as resources those personnel in Congo who have been well trained in family planning counseling and provision of methods. Reinforce technical knowledge as needed of the project technical areas (related to training, above). Ensure community involvement in the project so that the community understands and requests the health services that will be

reinforced by the project to their benefit. Train personnel in data collection and decision making at all levels, so that not only are the appropriate data being collected, they are used to "set the bar higher" and make programmatic decisions. Examine the possibility of providing computers and IT training at appropriate levels to facilitate reporting.

9. **Coordination**: From the central level in Kinshasa down to the health zone level, all people with whom we met emphasized the need for coordination among the levels of the MOH and the implementing partners in the Kasais. This would include sharing information, providing information on training sessions and including the appropriate personnel, sharing project indicators, etc.

   Recommendation: As noted above in #4, when LMS/DRC activities begin, the Ministry of Health will be informed at all appropriate levels, in writing, about the project's planned activities and their partnership in the process. LMS expects to carry out assessments in each health zone to look at needs, and these assessments will be carried out with the full knowledge and participation of appropriate MOH staff. MSH/LMS must coordinate routinely with other donors working in the two Kasai Provinces and immediately move to participate in any existing forums at that level or to put the appropriate mechanisms in place. In addition, MSH/LMS should also participate in the appropriate donor coordination forums at the central level, particularly as they related to any standardization in the delivery of services and technical assistance.

10. **Reinforcement of *équipe cadre***: The health zone management team has an important role to play in strengthening the health system, but this role has not been effectively reinforced.

    Recommendation: As above (#9), LMS expects the *équipes cadre* to fully participate in project activities in order to be strengthened in their performance and able to carry out their roles.

11. **Community involvement**: Most of the stakeholders to whom we spoke indicated the importance of enabling the community to play a role in its health care decisions. Yet it was clear that there was a dearth of information available to the community. Most of the health facilities we visited did not even have IEC materials available for their clients.

    Recommendation: MSH/LMS proposes enabling a "*partenariat pour l'amélioration de la qualité*" between health providers and the communities they serve. This partnership will give communities a voice in their health care as well as enable health care providers to better understand the needs of the communities they serve. This will be a process that assists the providers and communities to jointly consider health activities and priorities for the improvement of health service delivery. MSH/LMS will rely on the communication partner engaged by USAID to provide IEC materials with key health messages that can be used in community outreach. Although community involvement is key to several technical areas in which the project will be operating, one of the essential areas for rapid community involvement will be outreach and referral for fistula clients, once those referral systems are in place in our health zones.

12. **Reinforcement of systems**: The district health model is not functioning as envisioned, but it is also not linked with any kind of effective community support (mentioned several times here, e.g., identification of high-risk pregnancies at the community level and referral to appropriate level of health care would help reduce incidence of obstetrical emergencies and fistula). The health center and its corresponding health posts and community health workers should be providing the essential package of primary health care services. Communities are supposed to be participating in the management of these centers through management committees. The district hospital should be the first level of referral, for services such as basic surgery and emergency obstetrical care. Most

of these facilities, however, do not provide sufficient health coverage for the population, and the lines for referral are not respected. Hospitals and health centers are sometimes seen as competing with one another rather than working in complementarity.

Recommendation: MSH/LMS will work to strengthen the current health zones and investments that have been made by USAID to strengthen those health zones. This will mean reinforcing numerous systems that are in place or creating those systems where they are lacking. Part of ensuring the strengthening of these systems will be the progressive training of health managers through the Fully Functional Service Delivery Point Model and focusing on key systems such as referral, data collection and decision making, monitoring and evaluation, human resources, etc. The functioning of the management committees should be reviewed as part of regular monitoring and evaluation.

13. **Motivation**: The question of motivation is a difficult one. Most people with whom the team met consider "motivation" to be money; some even referred to it as "*professionalisme.*" Motivation is much more than money, however. It includes the creation of a more efficient and "comfortable" working climate in which people know and understand their roles and the roles of those with whom they work, have a common uniting vision, and know how they are going to move forward together as a team. The "*primes*" that have been provided to date by other donors have not focused on performance as the reason for the bonus, but rather focused on "topping off" salaries. This practice is not sustainable, and when a donor does not offer these "*primes*," health care personnel are frustrated.

    Recommendation: Explore alternative methods of inspiring and rewarding good performance, such as special designations for highly performing health facilities and designation of "community heroes" or similar titles for effective community-level work. LMS will ensure that appropriate costs are covered, such as formative supervision visits and associated cost, as well as ensuring that such visits take place as planned. Positive supervisory experiences will help reinforce performance. Performance-based contracting will be considered in year 2 of the project as another way to provide positive feedback at the facility level.

14. **Affordability of health care services**: Costs of delivery of health services are unregulated. Poverty and these unregulated users' fees have a negative impact on the population's ability to access health services. User fees are not posted in a prominent location.

    Recommendation: MSH/LMS has already asked USAID if there has been any consideration of *mutuelles de santé* as one approach to ensuring more accessibility to affordable health services. It seems like a strategy worthy of additional exploration as the project proceeds to reduce the financial barriers to accessing health services. If USAID is exploring this opportunity with other partners, MSH/LMS will explore how to link with that experience. Otherwise this is an option that we can explore directly. MSH/LMS should subsidize specialized care such as fistula repair for at least the first few years of the project while the fistula repair referral system is put into place. In project health zones, health facilities will be encouraged to post users' fees.

IX. Overall Recommended Strategy/Approach

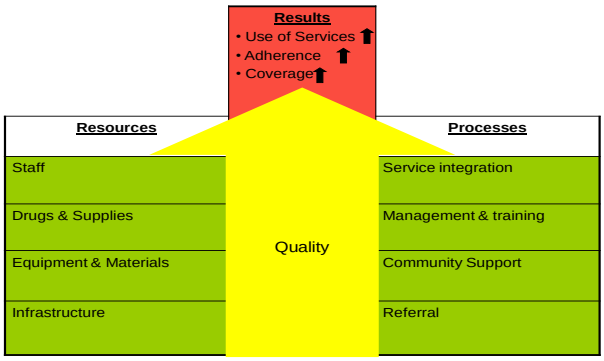
LMS/DRC activities will consist predominantly of primary health care/public health technical and management training and system strengthening through a Fully Functional Service Delivery Point (FFSDP) methodology for the 23 health zones identified earlier in this document. This can only be accomplished through the careful and probably phased introduction of the approach into the

health zones. It will require a strong collaboration between MSH/LMS at all levels in the country and the partners implementing services in the health zones. The provincial level will be involved to support strengthening, roll out, and institutionalization of FFSDP. Given the physical challenges in DRC, this will be challenging, but the structure suggested for the LMS/DRC project, described below, is optimal to adequately implement the approach. Some of the basic preconditions for introducing this model exist in DRC, including the existence of the *Stratégie de Renforcement du Système de Santé* (SRSS) and the defined minimum package of services.

In a post-conflict situation, in addition to the very visible destruction of infrastructure, the structural deterioration of civil society often leaves service providers without clear and common professional references. Both governmental and non-governmental agencies can benefit from a commonly accepted tool to evaluate quality of care. When adapted to the local situation, the FFSDS tool, which focuses on the service delivery point where the health system interacts with the community that should benefit from it, contributes to establishing vital links between the civil society and the government. A number of quality assurance (QA) and improvement (QI) tools and approaches exist, each with their own strengths and limitations. However, few of them (1) enable both expansion and QA/QI, (2) combine evaluation directly with education and intervention, (3) address both service delivery and service management, (4) actively engage all health facility staff in all steps of the application, and (5) can, once introduced, be fully implemented with local resources. The FFSDP encompasses all five features, and is therefore particularly suited for the challenges of rapid service expansion in a country as vast and as poor as DRC.

An FFSDP methodology is a standards-based whole-systems tool for service quality assurance, improvement and expansion. It is designed around the concept of “fully functional service delivery point”: the place where clients obtain and health providers deliver defined services of defined quality. The FFSDP defines quality as the simultaneous presence of all minimum elements. At the practical level, the standards can be adapted and adjusted based on local needs, norms, standards and guidelines, and on the specific service that is intended to be delivered. A service delivery point is considered fully functional if it meets a number of defined criteria, or quality standards, simultaneously. The criteria vary from one country to another based on local standards and resources. The definition of each criteria or quality standard may be all inclusive addressing, for instance, all basic health services, or it may be focused on one or only a few services. Finally, the definition of each standard as well as the selection of standards will be guided by national policy, guidelines, norms and standards specific to the level and type of health facility concerned (community based service, health post, health center, district hospital, regional hospital or national hospital). The FFSDP methodology enables health providers to identify and address strengths and weaknesses at the health facility and its surrounding catchment area, and to develop and implement actions that ensure quality, sustain strengths and correct weaknesses. While some actions are more input-based (e.g. improving infrastructure, procuring equipment and staff), others are more process-based, requiring longer-term corrective actions from the health providers (e.g. maintaining sanitary conditions at the health facility, handling of equipment, complying with clinical norms, standards and guidelines). However, all actions ultimately focus on improved outputs (e.g. better services, more use of services) and outcomes (e.g. improved adherence to treatment, increased condom use). The underlying assumption is that these outputs and outcomes will lead to improved and increased health impact.

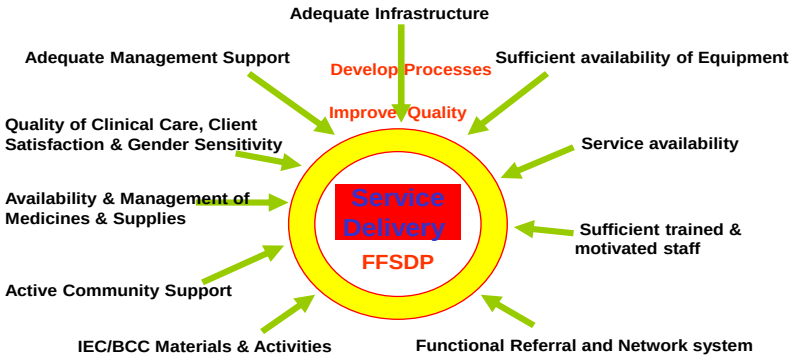
The relationship between FFSDP standards and health outcomes



The FFSDP methodology uses a continuous quality improvement model involving nine steps. The methodology is applied by the health facility staff and a FFSDP facilitator, and community members can be brought in as well in the assessment and action planning.

Set Quality Standards: The quality standards form the conceptual basis for the standards that the health center intends to meet. The standards are defined by national guidelines, and the components of each standard will therefore change when national guidelines change. The key elements or standards that must be present, at the same time, for a service delivery point to be considered fully functional, also have to take into consideration the type of service that is being offered (e.g. malaria services may call for different elements than, say, family planning or HIV/AIDS services). In some countries, the elements may also be broadened or narrowed, depending on needs and national guidelines. For instance, community support may mean community outreach and/or community participation.

FFSDP--Simultaneous Presence of Standards for Comprehensive PHC Services in DRC



Diagnose and Evaluate Standards: The standards are assessed with checklists, questionnaires, and observations using the evaluation tools that will be adapted for DRC.

Analyze: The tools help determine the degree to which the health facility complies with each standard through a scoring system. Scores for each component are rolled up into an overall score for the standard.

Identify Gaps and Strengths: The scores and the assessment identify areas where improvements must be made, and areas where good practices must be maintained. The analyzed results allow for identification of gaps, strengths and priorities for interventions.

Develop an Action Plan: Based on the findings, the health facility team develops an action plan to improve the quality standards, and with the assistance of the FFSDP facilitator, identifies the required internal and external resources (e.g. materials, TA). However, as much as possible, the action plan will identify internal resources and actions that do not depend on outside help. It is critical that all health facility staff be involved in the review of the findings, the development of the action plan, and the subsequent implementation. Their commitment is essential to the success of the tool.

Implement Action Plan: LMS will work with the teams and the zones to ensure regularly scheduled monitoring and assistance for the implementation of the action plan.

Evaluate Health Facility Performance Improvement: After 6 months, the full assessment is repeated using the same diagnostic tools as in step 3, and a comparison is made.

Recognize the Health Facility Achievements: Improvements are identified, for which the health facility may be recognized in some official manner, and further improvements are identified.

Raise the Bar through Continuous Quality Improvement: Continued challenges are identified, and the process repeats itself, until all standards are met. When all standards are met, raise the bar, and sustain performance improvement by continued application of the FFSDP approach.

FFSDP tool consists of three main components:

1. *The Evaluation Component*: On-site evaluations identify the challenges and areas where interventions are most needed. Repeat evaluations identify improvements over time, and the degree to which a health facility meets defined quality criteria.
2. *The Educational/Intervention Component*: During and between evaluations, supportive technical assistance through mentoring or supportive, formative supervision enables health providers and teams to perform continuous quality improvements with the goal of simultaneously reaching defined quality criteria.
3. *A Work Planning Component*: An action plan is developed based on a review and discussion of the data of the evaluation by the entire health center team. The plan is implemented by the health center staff through the educational/intervention component.

The three components are implemented using support documents and tools provided by the FFSDP toolbox. They include the following:

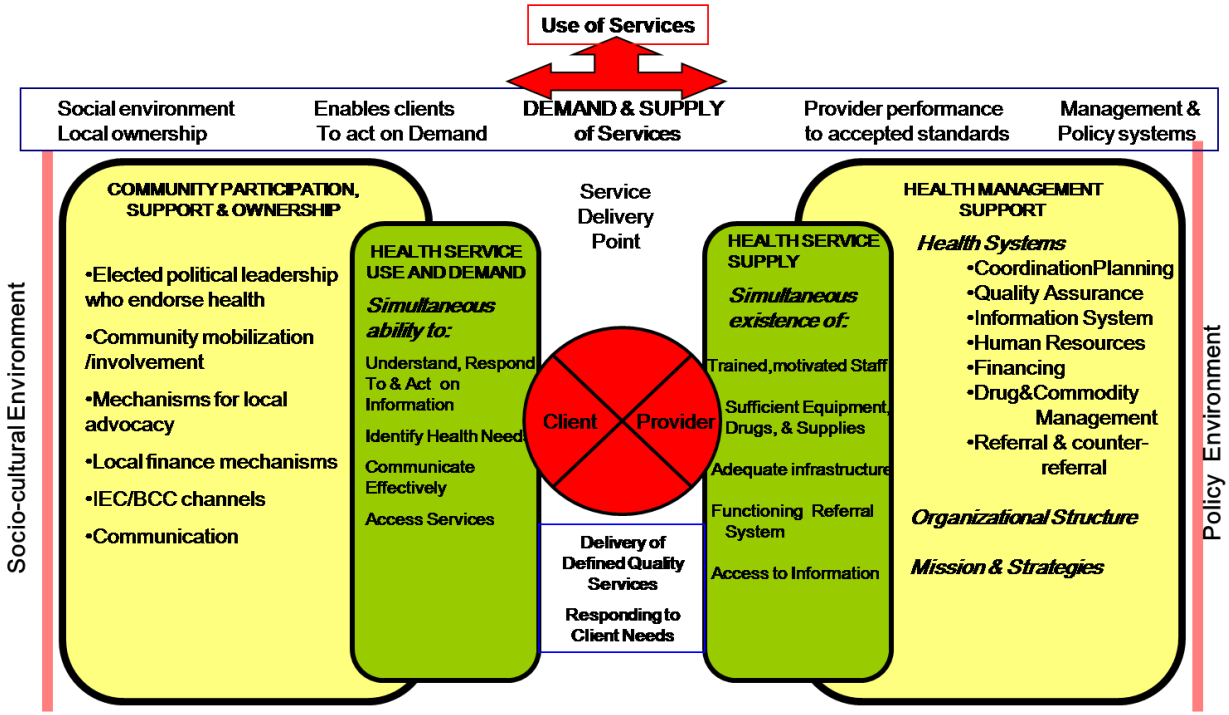
- *A standards-based evaluation package* to assess the current situation at a health facility. This package includes checklists, observation guides, questionnaires, interview protocols and an analysis tool.
- *An educational package* which shows to the health providers each step in making the necessary changes for attaining each standard of quality. The educational package includes a variety of management tools and documents which can be used by the health providers or adapted according to the local needs.
- *A workplan template* in the form of a Gantt chart, with guidance on how to develop and use a workplan based on the evaluation findings.

The FFSDP assists the health facilities to address the challenges in delivering services according to national norms and standards. To reiterate, a defined number of components of quality, each consisting of several standards, are evaluated against national quality standards. The components–such as infrastructure, equipment, supplies, staff, training, community approach,

community support, clinical quality, and management—are the elements that must be present simultaneously at any given service delivery point. The evaluation of these components pinpoints strengths and weaknesses in management support systems and in service delivery for each health facility, or service delivery point (be it formal or informal, as is the case, for instance, with community health workers) and, through aggregation, for each NGO partner of the MOH. The methodology enables the health providers to identify and address weaknesses at the health facility and its surrounding catchment area, and may be used by supervision teams and implementing teams alike. While some components are more input-based (infrastructure, equipment and staff), the other components require longer-term corrective actions from the health providers. The FFSDP tool can be used by the provincial, district, and health zone levels as a monitoring tool, and it can be used as well for internal and external evaluations. However, as the evaluation is only one of three components in implementing the FFSDP, more often than not, the FFSDP tool is used as a quality improvement tool by the health facility, its teams, and their supervisors. In places where communities can be engaged, they too can participate in the use of the FFSDP. The FFSDP brings stakeholders together, builds teams, and reinforces and promotes, at the facility level, the quality of delivery of the minimum package of services; the implementation and use of the national Health Management Information System, the supervision of community health workers, and the involvement of the communities living within the catchment area of the health facilities. The methodology will provide a standardized approach to introduce and monitor the prerequisites for quality of services delivered at the health facility and community level, allowing a standardized approach to supervision and monitoring of individual facilities. The FFSDP promotes a sustainable approach in bringing behavioral changes to encourage more public-health oriented practices of the health providers, and it has proven to be very effective in supervising, monitoring, and evaluating public health changes as a project proceeds.

The graphic of the full model is presented below.

Support Systems for the Fully Functional Service Delivery Point



At the end of the MSH/LMS DRC project, all health facilities in the project health zones will routinely use the FFSDP tool resulting in:

- Improved compliance with FFSDP quality standards, associated with improved coverage of Comprehensive PHC services at health centers linked to their communities;
- Health managers use the FFSDP monitoring instrument routinely in planning, organizing, performance improvement and decision making;
- A behavioral shift among local health providers and communities from focusing primarily on medical and clinical services to emphasizing preventive and public health services, thus improving the health of the people and families served.

Selected MSH tools will be used at various points of this model to build the necessary capacity. For example, a Leadership Development Program (LDP) is proposed for provincial and zonal staff to ensure that there is a common vision and clear understanding of the respective roles and responsibilities. LDPs are primarily for teams (zonal, facility, hospital department, and so forth), not for individuals. The LDP will be initiated during the first year with a limited number of teams in order to build up the local facilitator network, train monitors, and study initial successes, with a view to scaling up the process during the subsequent years. We will look at progressively introducing this approach to the geographic "clusters" of health zones. Key challenges for the LDP will be selected from the project's technical areas (malaria, MCH, FP/RH, and so forth), and the LDP process will be used as a model to address additional challenges in the future.

All other project activities for training, supervision, monitoring, and reporting will be focused at the provincial, zonal, and facility levels. Leadership, management, and coordination capabilities will be strengthened at the provincial level through initial diagnosis of management needs using the Management Organizational Sustainability Tool (MOST) or similar assessment tool, with resulting action plans addressed through targeted TA and workshops. Likely areas of intervention include governance, strategic planning, financial management, and human resources.

The project's role in improving coordination, both between levels of the health care system and between partners/donors is recognized, and resources will be devoted to this area. The office in Kinshasa will be responsible for meeting at the national level with donors and the Ministry to ensure that GRDC policies, procedures, norms and standards are properly documented and communicated to the provincial, health zone, and facilities level.

An assessment of the feasibility to institute a performance-based funding (PBF) strategy in the Kasais will be budgeted in the second year of the project. MSH staff with experience in one of the other MSH project countries where a PBF scheme has been implemented (such as Haiti or Rwanda) will participate in this assessment. From this, conclusions, recommendations, and a draft PBF strategy will be presented to the Mission.

LMS/DRC will work with the projects identified by USAID/DRC to lead efforts in IEC/BCC and drug supply systems/logistics/supplies, and will incorporate their approaches as appropriate into the LMS activities.

LMS/DRC may subcontract locally with NGO partners to assist in certain aspects of the project's work, such as the "***village assaini***" program and **referral systems for fistula repair**. One potential partner has been identified for the health zones around Luiza: the Christian Medical Institute of the Kasai (IMCK) in Tshikaji. Dr. Leon Mubikayi and Dr. Michael Henninger perform fistula repair and have expressed interest in developing into a center of excellence for fistula repair. A subcontract would permit MSH to support the transportation, repair, and recuperation for women with fistulas from the health zones. This approach is appropriate in the short term while the health zones are being reinforced. LMS has already been in contact with the Fistula Care Project/EngenderHealth about its activities, and will maintain contact to get updated information on which resources can be accessed for fistula repair elsewhere in the LMS health care zones. UNFPA noted that it will train doctors from Lodja in fistula repair (with the planned

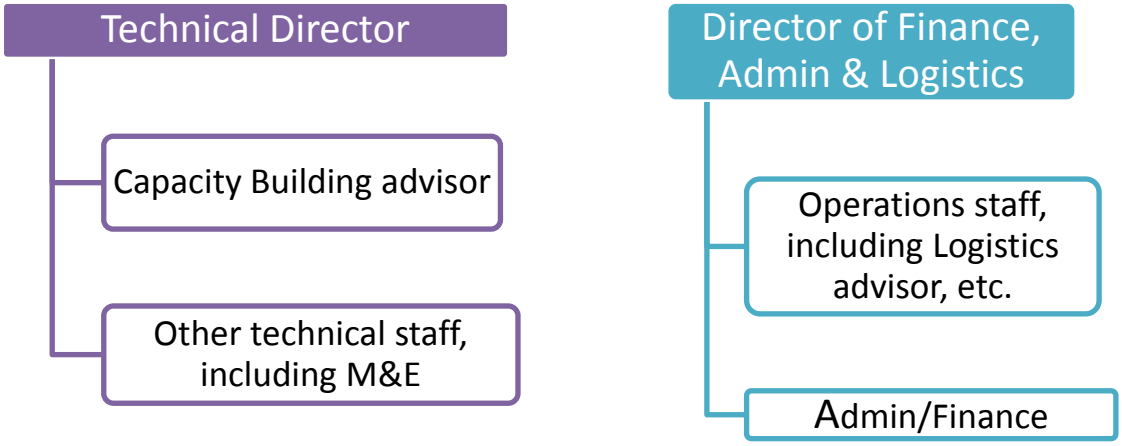
training to take place in Tshikaji). We will explore the feasibility of these doctors, based in Lodja, being the referral points for our health zones in the north.

As the project progresses, MSH/LMS will work with USAID on adding additional health zones, as appropriate, to the LMS-supported zones, as well as to identify opportunities for scale up of LMS approaches.

X. Recommended Structure of Project

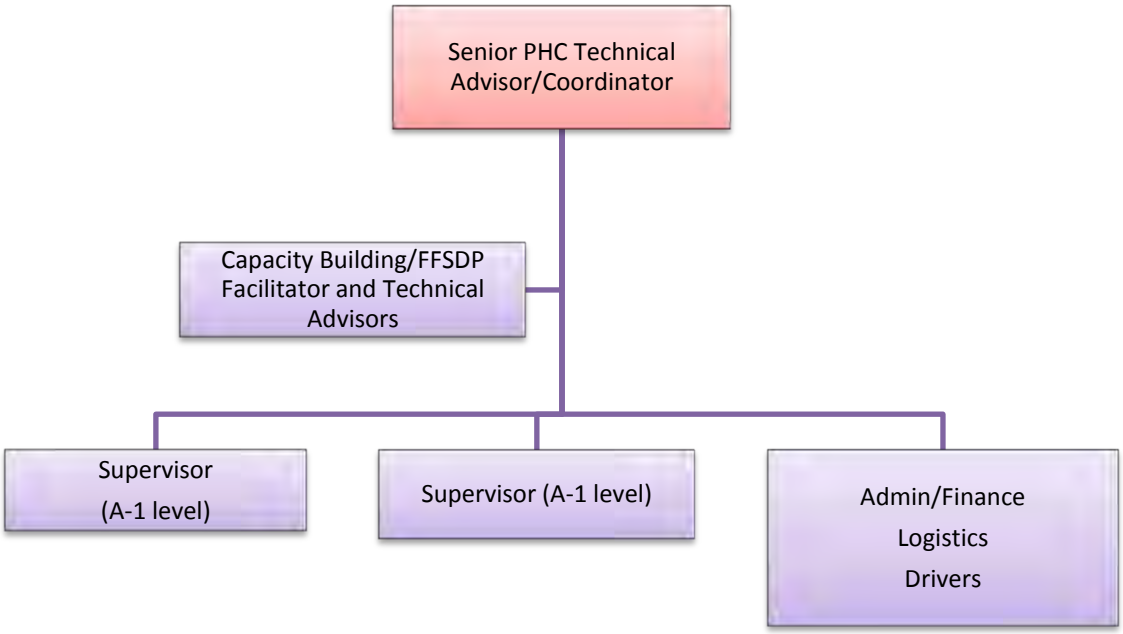
LMS/DRC will have a small central office (in Kinshasa), co-located with other MSH activities (to share key systems and save project resources) and four coordination offices—two each in Kasai Occidental and Kasai Oriental.

The central office structure will include the following:



As confirmed by USAID during the assessment visit, the central office will serve an important liaison role with USAID and, as described elsewhere in this report, will coordinate with key actors at the central level to ensure harmonization of approaches at the health zone level. In addition, particularly in the area of Finance and Operations, the central office will oversee the effective implementation of project resources and build capacity at the health zone level. The Project Director/Technical Advisor and Director of Finance, Administration and Logistics should reside in Kinshasa and travel at least quarterly to each coordination office. The Director of Finance, Administration, and Logistics will be shared by other MSH projects to ensure consistent systems and approaches. Based on lessons learned in other large, complex country programs, as well as the findings of the assessment visit, MSH envisions hiring a highly-qualified expatriate for this post, preferably with MSH and extensive USAID project experience.

The four Coordination Offices, to be located in Luiza, Mbuji-Mayi (or possibly Mwene Ditu), and Lodja/Kole (northern locations to be determined, based on discussion with USAID, partners, and analysis of transportation routes, accessibility to zones, etc.) will be responsible for project implementation and coordination of activities with local stakeholders and will include the following:



Supervisors (8 positions total) will regularly visit 2-3 health zones each and will ensure participation of the appropriate level of MOH staff for visits. Each will be motorcycle competent.

In Kananga, the presence will be limited to a liaison co-located at the Province level (a capacity building/FFSDP advisor), while the main office will be based in Luiza. If we decide to locate the second office in Mwene Ditu, a similar position should be considered for the provincial Ministry of Health in Mbuji Mayi. To the extent possible, ALL coordination offices will be co-located with the Ministry of Health to promote greater partnership and ownership.

There should be one "Senior PHC Technical Advisor/Coordinator" for each coordination office who:

1. Oversees the work of the supervisors
2. Is chief instructor in technical subjects both for project staff as well as partners
3. Maintains liaison with Government health authorities

The four Senior PHC Technical Advisors/Coordinators will

- Report to the Kinshasa office
- Lead and manage staff and activities at the provincial level
- Be equipped to travel freely throughout the two Kasais
- Negotiate special services, e.g., fistula repair
- Oversee any local subcontracts for special services
- Arrange technical assistance

The coordination offices will have a "Capacity Building Advisor" who will assess capacity building needs and coordinate with technical advisors. Depending on need, each office could have a range of "Technical Specialists" (MCH, HIV/AIDS, infectious diseases).

Each “bureau de coordination” will have a vehicle (land cruiser type) and motorcycles/all terrain vehicles (capable of transporting some supplies) for supervisory visits. The Kinshasa office will have one land cruiser. Additional transport needs will be assessed as the project progresses and will include motorized pirogues, access to humanitarian flights on approved air travel providers, etc.

Since the assessment, MSH/LMS has been actively putting in place many of the prerequisites for the timely commencement of project activities (e.g., development of job descriptions, recruitment for key positions, including collection of CVs locally for positions in the coordination offices, documentation with the Ministry of Planning for registration in country and access to the humanitarian airline, AirServ, identification and rental of Kinshasa office, coordination with other MSH activities in country, IT assessment for all offices, setting up codes for the project, assessment, documenting vehicle needs for waivers from USAID/W, reviewing consultants to assist with rapid project start up, developing initial travel plans, setting up communication mechanisms, getting the home office team in place, and developing standard operating procedures for the DRC offices). In collaboration with USAID and its stakeholders, and as results are obtained by the project, LMS will continue to ensure that the project is implemented effectively and as rapidly as possible. In order to coordinate with USAID, as of November 2008 MSH/LMS will develop regular communication mechanisms to keep USAID informed of progress on a mutually agreeable schedule.

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	Gestion de medicaments dans les zones de santé assistees par CRS au Kasai, John Gikapa, Gabriel Bukasa, Aout 2008	LMS DRC e-room
	USAID/Democratic Republic of Congo (DRC) Primary Health Care Project in West/Central Congo (LMS SOW)	
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	Projet AXxes Partner Implementation Map	
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